STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 00 B. WING	02/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL HEALTH CAMPUS	101 W 87TH AVE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaint IN00104470. Complaint IN00104470- Substantiated, Federal/State deficiencies related to the allegations are cited at F225 and F226. Survey date: February 27, 28, and 29, 2012 Facility number: 010739 Provider number: 155764 AIM number: N/A Survey team: Marcia Mital, RN, TC Regina Sanders, RN Sheila Sizemore, RN Kelly Sizemore, RN Census bed type: SNF: 48 Residential: 67 Total: 115 Census Payor type: Medicare: 40 Other: 75 Total: 115 Sample: 3 Residential sample: 2	F0000	The submission of this plan of correction does not indicate an admission by Spring MIll Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Spring Mill Health Campus . This facility recognized its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities.(for Title 18/19 programs). To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statue only .	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on March 1, 2012 by Bev Faulkner, RN			

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F0225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and interview, the	F0225	1. Further investigation was completed at the time of the survey. No negative outcomes	03/23/2012

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	facility failed to thoroughly investigate and report an allegation of abuse to the Indiana State Department of Health (ISDH) timely, and failed to ensure residents' were protected after an allegation of abuse was voiced, for 1 of 3 residents reviewed for abuse in a total sample of 3. (Resident #D) Findings include: Resident #D's record was reviewed on 02/28/12 at 8:30 a.m. The resident's diagnoses included, but were not limited to, dementia and anxiety. The resident had been admitted to the Healthcare unit on 02/17/12 at 12:20 p.m. The record indicated the resident had lived on the Legacy Unit (Alzheimer's Unit) at the facility prior to this admission. The resident's behavior report, dated 02/21/12 through 02/28/12, indicated the resident exhibited no behaviors. The resident's admission assessment, dated 02/17/12 and untimed, indicated the resident's speech was understood and the resident understood communications. The assessment indicated the resident had short and long term memory problems, and required one assistant for activities of		were noted.2. All residents are at risk for the alleged deficiency. Investigations for incidents will be reviewed for thoroughness and appropriate notification to ISDH (Indiana State Department of Health) by the DHS/designee. Additional investigating or reporting will be completed. accordingly . 3. DHS or designee will in-service nurses on investigation procedures on facility policy and state reportable guidelines. Nurses will be required to notify the Executive Director or designee of situations requiring an incident report .4. DHS or designee will review investigations within 24 hours of the incident and report to ISDH accordingly. Trends will be brought to monthly QA X 6 months or until 100% compliance is achieved.Compliance date : 03/23/12	

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	daily living. A Nurses' Note, dated 02/17/12 at 2:30 p.m., indicated, "Informed DON (Director of Nursing) (DoN's name) and ADoN (Assistant Director of Nursing name) that Resident c/o (complained of) (CNA #1 name) (Male CNA) of being fresh, (CNA #1 name) was not in the room by himself c/ (with) Resident, (CNA #2 name) was in room c/ him, (CNA #2 name) state [sic] that (CNA #1 name) did not say any &/or touch resident is [sic] was just in the room, Inform (CNA #1 name) not to go back in room & to have a female to take care of Resident. I pass on it to (sic) evening shift for female only to take care of resident." A Nurses' Note, dated 02/17/12 at 3 p.m., indicated, "Spoke c/ resident et POA (Power of Attorney) (Name), resident prefers for females to care for her. Resident stated that above named CNA entered her room et introduced self & she does not want men/boys care for her. Info noted." (This was written by the DoN) There was a lack of documentation to indicate a thorough investigation had been completed, an assessment of the resident had been completed, the resident's physician being notified,the Administrator had been notified, and the			

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	ISDH being notified after the resident indicated the male CNA had been "fresh" with her. During an interview on 02/28/12 at 9:05 a.m., the DoN indicated she spoke with the resident and the POA. She indicated the male CNA had not touched the resident. She indicated she did not investigate or report the allegation. She indicated she had not talked to the resident about what she meant about the CNA being "fresh" since the other CNA had said CNA #1 had not touched or said anything to the resident. During an interview on 02/29/12 at 9:57 a.m., the DoN indicated she thought she notified the Administrator, but was not sure if she had notified him that day. She indicated she was unsure when she notified him. She indicated she didn't think it was an allegation because there was another CNA in the room and was told CNA #1 had not touched the resident. During an interview on 02/29/12 at 10:08 a.m., the Administrator indicated he did not remember the incident being reported to him. He indicated the first time he had heard about it, to the best of his recollection, was 02/28/12. (This was 7 days after it had occurred.)			

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	During an interview on 02/28/12 at 11:30 a.m., LPN #3 (nurse on duty at the time of the allegation) indicated she was doing an assessment on the resident when the resident told her CNA #1 had been "fresh" with her. She indicated she had asked the resident what she meant by being fresh, and the resident did not answer her question. LPN #3 then indicated she had left the room and then returned to the room about 15 minutes later and Resident #D again told her CNA #1 had been fresh with her. LPN #3 indicated CNA #1 had not been back in the resident's room. LPN #3 indicated when the resident made the allegation the second time, she then went and talked to CNA #1 and CNA #2 and her documentation in the chart about the allegation of CNA #1 was completed only after the resident had repeated the allegation again, 15 minutes after the first allegation. LPN #1 indicated since the resident had repeated the allegation again, she then told the DoN and the ADoN and decided she had better document the allegation. LPN #3 indicated she had not told CNA #1 to stay out of the resident's room, until the resident repeated the allegation. She indicated CNA #1 had been doing rounds with other residents. LPN #1 indicated a Circumstance Form had not been filled out. She indicated she had not notified the resident's physician			

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	about the allegation. This Federal tag relates to Complaint IN00104470. 3.1-28(d)			

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F0226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to follow their policy for abuse, related to reporting abuse allegations to the facility Administrator, the Indiana State Department of Health (ISDH), and the residents' physician, the facility also failed to completed a thorough investigation and protect the residents after an allegation of abuse for 1 of 3 residents reviewed for abuse allegations in a total sample of 3. (Resident #D) Findings include: Resident #D's record was reviewed on 02/28/12 at 8:30 a.m. The resident's diagnoses included, but were not limited to, dementia and anxiety. The resident had been admitted to the Healthcare unit on 02/17/12 at 12:20 p.m. The record indicated the resident had lived on the Legacy Unit (Alzheimer's Unit) at the facility prior to this admission.	F0226	1. Further investigation was completed at the time of the survey. No negative outcomes were noted.2. All residents are at risk for the alleged deficiency. Investigations for incidents will be reviewed for thoroughness and appropriate notification to ISDH (Indiana State Department of Health) by the DHS/designee. Additional investigating or reporting will be completed. accordingly . 3. DHS or designee will in-service nurses on investigation procedures on facility policy and state reportable guidelines. Nurses will be required to notify the Executive Director or designee of situations requiring an incident report .4. DHS or designee will review investigations within 24 hours of the incident and report to ISDH accordingly. Trends will be brought to monthly QA X 6 months or until 100% compliance is achieved.Compliance date : 03/23/12	03/23/2012

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The resident's behavior report, dated 02/21/12 through 02/28/12, indicated the resident exhibited no behaviors.

The resident's admission assessment, dated 02/17/12 and untimed, indicated the resident's speech was understood and the resident understood communications. The assessment indicated the resident had short and long term memory problems, and required one assistant for activities of daily living.

A Nurses' Note, dated 02/17/12 at 2:30 p.m., indicated, "Informed DON (Director of Nursing) (DoN's name) and ADoN (Assistant Director of Nursing name) that Resident c/o (complained of) (CNA #1 name) (Male CNA) of being fresh, (CNA #1 name) was not in the room by himself c/ (with) Resident, (CNA #2 name) was in room c/ him, (CNA #2 name) state [sic] that (CNA #1 name) did not say any &/or touch resident is [sic] was just in the room, Inform (CNA #1 name) not to go back in room & to have a female to take care of Resident. I pass on it (sic) to evening shift for female only to take care of resident."

A Nurses' Note, dated 02/17/12 at 3 p.m., indicated, "Spoke c/ resident et POA (Power of Attorney) (Name), resident

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	prefers for females to care for her. Resident stated that above named CNA entered her room et introduced self & she does not want men/boys care for her. Info noted." (This was written by the DoN) There was a lack of documentation to indicate a thorough investigation had been completed., an assessment of the resident had been completed, the resident's physician being notified,the administrator had been notified, and the ISDH being notified after the resident indicated the male CNA had been "fresh" with her. During an interview on 02/28/12 at 9:05 a.m., the DoN indicated she spoke with the resident and the POA. She indicated the male CNA had not touched the resident. She indicated she did not investigate or report the allegation. She indicated she had not talked to the resident about what she meant about the CNA being "fresh" since the other CNA had said CNA #1 had not touched or said anything to the resident. During an interview on 02/28/12 at 11:30 a.m., LPN #3 (nurse on duty at the time of the allegation) indicated she was doing an assessment on the resident when the resident told her CNA #1 had been "fresh" with her. She indicated she had asked the resident what she meant by			

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	being fresh, and the resident did not answer her question. LPN #3 then indicated she had left the room and then returned to the room about 15 minutes later and Resident #D again told her CNA #1 had been fresh with her. LPN #3 indicated CNA #1 had not been back in the resident's room. LPN #3 indicated when the resident made the allegation the second time, she then went and talked to CNA #1 and CNA #2 and her documentation in the chart about the allegation of CNA #1 was completed only after the resident had repeated the allegation again, 15 minutes after the first allegation. LPN #1 indicated since the resident had repeated the allegation again, she then told the DoN and the ADoN and decided she had better document the allegation. LPN #3 indicated she had not told CNA #1 to stay out of the resident's room, until the resident repeated the allegation. She indicated CNA #1 had been doing rounds with other residents. LPN #1 indicated a Circumstance Form had not been filled out. She indicated she had not notified the resident's physician about the allegation. During an interview on 02/29/12 at 9:57 a.m., the DoN indicated she thought she had notified the Administrator, but was not sure if she notified him that day. She indicated she was unsure when she			

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	notified him. She indicated she didn't think it was an allegation because there was another CNA in the room and was told CNA #1 had not touched the resident. During an interview on 02/29/12 at 10:08 a.m., the Administrator indicated he did not remember the incident being reported to him. He indicated the first time he had heard about it, to the best of his recollection, was 02/28/12. (This was 7 days after it had occurred.) A facility policy, dated 09/16/11, and received from the Administrator as current, titled, "ABUSE AND NEGLECT PROCEDURAL GUIDELINES", indicated, "...5. Staff is required to report concerns, incidents and grievances immediately to your manager and/or Executive Director and Director of Health Services...IMMEDIATELY notify the Executive Director...The Executive Director or designee must notify the residents(s)' physician(s) and family/responsible party...Complete an Accident and Incident Report. Refer to the Accident and Incident Program...The Executive Director is responsible for: 1. Notification to the State Department of Health...Protection...Upon identification of suspected abuse...immediately provide for the safety of the resident...This may			

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	include...Providing 1:1 monitoring...Suspend suspected employee pending outcome of investigation...The Executive Director is accountable for investigating and reporting...Immediately and not more than 24 hours complete an initial report to applicable state agencies..." An undated, facility policy received from the DoN on 02/27/12 at 3:15 p.m., titled, "ACCIDENT AND INCIDENT REPORTING GUIDELINES", indicated, "...To ensure all accidents, incidents and allegations of abuse involving residents...are investigated and reported to the facility administration...An Accident and Incident Form shall be completed for known...abuse allegations...The assigned nurse or nursing supervisor shall complete an assessment and provide medical interventions as warranted. 5. Reporting of incident, accidents and abuse to state and federal agencies shall be in compliance in accordance with agency guidelines...7. The assigned nurse or nursing supervisor shall: 1. Examine all accident, incident or abused victims. b. Notify the attending physician or medical director of the occurrence...8. Investigative action shall be initiated by the attending nurse and/or nursing supervisor by completing the appropriate 'Circumstance and Reassessment form'			

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	and forwarded to the Director of Health Services...." This Federal tag relates to Complaint IN00104470. 3.1-28(a)			